Benefit Enrollment and Life Event Change Form

A

☐ Adding Dependent (check one)	☐ Removing Dependent (check one)	☐ New Enrollment (check one)	Employer Name and Address: **State of New Hampshire 25 Capitol Street, Concord, NH 03301**	
☐ Marriage ☐ Birth ☐ Legal Guardianship/Court Order ☐ Adoption ☐ Loss of Other Coverage	☐ Divorce/Legal Separation ☐ Death ☐ Access to Other Coverage	☐ New Hire or ☐ Rehire < 1 year ☐ PT employee, benefit eligible ☐ Return from LOA ☐ RIF or Recall Placement ☐ Loss of Other Coverage	Employee Social Security #: NH FIRST Employee ID #:	Union Affiliate: ☐SEA ☐TEAMSTERS 633 ☐TROOPER ☐NEPBA 260 ☐UNREPRESENTED ☐NEPBA 240 ☐NEPBA 265 ☐NEPBA 245 ☐NEPBA 270

B

Employee Name (PLEASE PRINT): *(First Name / Middle Initial / Last Name)*	Employee Date of Birth: *(MM/DD/YYYY)* _____/_____/_____	Work Phone: Home Phone:
Address *(Street)* *(City)* *(State)* *(Zip Code)*		

C

First Name Middle Initial Last Name	Add, Waive or Remove	Date of Birth	Gender	Coverage Selection	2013 FSA Elections	**Anthem PCP Number** (If a name is entered without a number, no PCP will be assigned)	Existing Patient
Employee **SAME AS ABOVE**	☐ Add ☐ Waive	**SAME AS ABOVE**	☐ M ☐ F	☐Dental ☐Medical ☐ HMO ☐ POS	☐Medical ($2500 max) $_____ / Year ☐Waive Medical ☐Child Care ($5000 max) $_____/Year ☐Waive Child Care		☐ Yes ☐ No
Spouse/Same Gender Spouse **Relationship** ☐ Spouse ☐ Same Gender Spouse Name: _____ Spouse's SSN: _____ - _____ - _____	☐ Add ☐ Remove	Date of Birth ____/____/_____	☐ M ☐ F	☐Dental ☐Medical ☐HMO ☐POS			☐ Yes ☐ No
Additional dependent children should be listed on a second enrollment form. Dependent **Relationship** ☐ Employee's Dependent ☐ Dependent of Same Gender Spouse Dependent Name: _____ Dependent SSN: _____ - _____ - _____	☐ Add ☐ Remove	Date of Birth ____/____/_____	☐ M ☐ F	☐Dental ☐Medical ☐HMO ☐POS			☐ Yes ☐ No
Dependent **Relationship** ☐ Employee's Dependent ☐ Dependent of Same Gender Spouse Dependent Name: _____ Dependent SSN: _____ - _____ - _____	☐ Add ☐ Remove	Date of Birth ____/____/_____	☐ M ☐ F	☐Dental ☐Medical ☐HMO ☐POS			☐ Yes ☐ No

D

The information provided above is true and correct to the best of my knowledge. I also understand that the dependent coverage will not be effective until I provide appropriate documentation to my agency Human Resource office.

Employee Signature:_____ **Date:** _____/_____/_____ ** **Please make a copy of this form for your personal records****

For Agency Benefit Representative Use Only	Agency Name	Agency Benefit Representative Name	Contact #	Date Sent to DOP	Event Date (Date of Hire or Life Event)	Coverage Start or End Date
Payroll #: _ _ _ _						

Date BASS Updated: _____ Initials: _____ Date NH FIRST Updated: _____ Initials: _____ **Revised June 17, 2013 /TH**